

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-002718

STATE FILE NUMBER

AMENDED

Registration District No. 309

Primary Registration District No. 3043

Registrar's No. # 4

FILED JAN 15 1962

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ill.</b> b. COUNTY <b>Pike</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		c. CITY OR TOWN <b>Hull</b>	
Length of stay in 1b <b>DOA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Elizabeth Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>R # 1</b>	
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Harry</b> Last <b>Peters</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>5</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 99</b>
9. AGE (last birthday) <b>(62)</b>		IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (City and state or country) <b>Hull, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Frederick W. Peters</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Frances Bencke</b>	
14. NAME OF HUSBAND OR WIFE <b>Ruth Peters</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT <b>Ruth Peters</b>		Address <b>Hull, Ill. R # 1</b>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive coronary infarction</b> Interval between ONSET AND DEATH <b>Instant</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hannibal Marion Mo.</b>	
20f. CITY, TOWN, OR LOCATION <b>Hannibal Marion Mo.</b>		COUNTY <b>Mo.</b> STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on <b>12/6/61</b> Death occurred at <b>3:00 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. H. Winterschmid</b>		22b. ADDRESS <b>1209 Broadway, Hannibal, Mo.</b>	
22c. DATE SIGNED <b>1/6/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan 8, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Barry, Ill.</b>	
24. FUNERAL DIRECTOR <b>Clark Funeral Home - Hannibal, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Jan. 6, 1962</b>	
26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Bencke by Lillian A. Norman</b>			

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

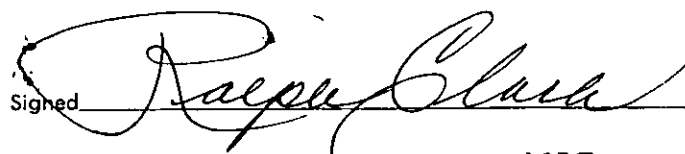
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 4217

P. O. Address Hannibal, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.